Legislative Assembly of Ontario

Assemblée législative de l'Ontario

Official Report of Debates (Hansard)

M-18

Standing Committee on the Legislative Assembly

Protecting Patients Act, 2017

2nd Session
41st Parliament

Wednesday 10 May 2017

Chair: Monte McNaughton
Clerk: William Short

Journal des débats (Hansard)

M-18

Comité permanent de l'Assemblée législative

Loi de 2017 sur la protection des patients

2e session
41e législature

Mercredi 10 mai 2017

Président : Monte McNaughton
Greffier : William Short

Hansard on the Internet

Hansard and other documents of the Legislative Assembly can be on your personal computer within hours after each sitting. The address is:

Le Journal des débats sur Internet

L'adresse pour faire paraître sur votre ordinateur personnel le Journal et d'autres documents de l'Assemblée législative en quelques heures seulement après la séance est :

http://www.ontla.on.ca/

Index inquiries

Reference to a cumulative index of previous issues may be obtained by calling the Hansard Reporting Service indexing staff at 416-325-7400.

Renseignements sur l'index

Adressez vos questions portant sur des numéros précédents du Journal des débats au personnel de l'index, qui vous fourniront des références aux pages dans l'index cumulatif, en composant le 416-325-7400.

Hansard Reporting and Interpretation Services
Room 500, West Wing, Legislative Building
111 Wellesley Street West, Queen's Park
Toronto ON M7A 1A2
Telephone 416-325-7400; fax 416-325-7430
Published by the Legislative Assembly of Ontario

Service du Journal des débats et d'interprétation
Salle 500, aile ouest, Édifice du Parlement
111, rue Wellesley ouest, Queen's Park
Toronto ON M7A 1A2
Téléphone, 416-325-7400; télécopieur, 416-325-7430
Publié par l'Assemblée législative de l'Ontario

ISSN 1180-436X

CONTENTS

Wednesday 10 May 2017

LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON THE LEGISLATIVE ASSEMBLY

COMITÉ PERMANENT DE L'ASSEMBLÉE LÉGISLATIVE

Wednesday 10 May 2017

Mercredi 10 mai 2017

The committee met at 1230 in committee room 1.

PROTECTING PATIENTS ACT, 2017
LOI DE 2017 SUR LA PROTECTION DES PATIENTS

Consideration of the following bill:

Bill 87, An Act to implement health measures and measures relating to seniors by enacting, amending or repealing various statutes / Projet de loi 87, Loi visant à mettre en oeuvre des mesures concernant la santé et les personnes âgées par l'édiction, la modification ou l'abrogation de diverses lois.

The Chair (Mr. Monte McNaughton): Good afternoon, everyone. We're going to begin. We are, as the committee knows, on a tight time schedule today. Welcome to the Standing Committee on the Legislative Assembly. We're here for public presentations on Bill 87.

First off, I'd like to let the committee know that there has been a request from the subcommittee to extend written submissions to 10 a.m. tomorrow. Is the committee okay with that? Agreed? Agreed. Perfect.

COLLEGE OF NURSES OF ONTARIO

The Chair (Mr. Monte McNaughton): We would now like to call upon the College of Nurses of Ontario, please.

Good afternoon. You'll have six minutes for your presentation, followed by three minutes of questioning from each caucus, beginning with the opposition. If you could both state your name for Hansard, and then begin.

Ms. Megan Sloan: Good afternoon. My name is Megan Sloan, and I am president of the council of the College of Nurses of Ontario. Here with me today is Kevin McCarthy. He's the director of strategy at the college.

I'm pleased to be speaking to you today on behalf of the college. We serve the public by regulating Ontario's 160,000 nurses. Under the Regulated Health Professions Act, the college ensures that those applying to become nurses meet the requirements for entering practice. The college also sets the practice standards for nurses, and enforces those standards through a number of processes, including disciplinary hearings.

The College of Nurses of Ontario supports the intent and goals of Bill 87. With this in mind, we would like to offer input on the following areas:

—transparency;

—earlier interim suspensions;

—the definition of the term "patient";

—funding for sexual abuse victims; and

—the structure and composition of committees.

On transparency: The college supports providing the public with more information about nurses. Along with our counterparts in the Advisory Group for Regulatory Excellence, called AGRE, the College of Nurses is recognized as a leader in transparency.

In December 2015, our council proactively implemented changes to our public register. They include:

—full discipline committee information;

—disciplinary hearing notices;

—criminal findings of guilt relevant to a member's practice; and

—bail conditions relevant to a member's practice.

This demonstrates that the college is committed to public access to relevant information about nurses' practice.

The College of Nurses supports the change to interim suspensions outlined in Bill 87. This gives the investigations, complaints and reports committee, the ICRC, the authority to suspend a nurse's certificate earlier on in an investigation.

Under Bill 87, colleges can act more quickly when significant public safety concerns are identified. Currently, if a nurse is arrested and charged with sexually assaulting a client, the college cannot suspend or restrict the nurse's practice until the investigation is completed and the ICRC refers the matter to the discipline committee. But in cases like this, the public expects a regulator to respond quickly and eliminate the risk.

The College of Nurses defines the term "patient" or "client" as a person who has a therapeutic relationship with a nurse. Trust, respect, empathy and power are all part of the therapeutic relationship, regardless of how long the interaction between the patient and the nurse.

Nurses are always responsible for maintaining the limits or boundaries of this relationship. The instant a nurse engages in a therapeutic relationship, regardless of the context or the length of the interaction, the college expects that the nurse will comply with all professional standards.

In some situations, it is never appropriate for a nurse to engage in a personal relationship with a former client, no matter how much time has passed since the nurse

provided care. This is why the college believes a definition of "patient" should focus on the safety and well-being of patients, rather than on the interests of the profession.

On funding for victims of sexual abuse: The college supports expanding access to funding to patients who allege they were sexually abused by a nurse. This would allow us to make funding available earlier. The college has previously made funding available to victims outside of the legislation and regulation.

We would be pleased to work with the minister to ensure that new regulations increase access to funding and ensure colleges are not unintentionally limited when providing funding to victims of sexual abuse.

Finally, Bill 87 gives the minister regulation-making powers to determine the structure and composition of committees. Having the right expertise on statutory committees is essential to decisions that put patients first.

We believe that nurses and public members who serve on statutory committees should be appointed based on their knowledge, skills and attributes or competencies relevant to the committee's mandate and goals. For example, the discipline committee needs members who can objectively assess information they've received from multiple sources.

Recently, our council discussed the value of competency-based appointments. We believe they make regulatory processes more effective. We look forward to discussing this with the minister when the time comes to make these regulations.

This concludes my remarks. We would like to thank you for the opportunity to present to you this afternoon.

The Chair (Mr. Monte McNaughton): Thank you very much. We'll move to the official opposition for questions. Mr. Yurek.

Mr. Jeff Yurek: Thank you for being here and giving your deputation. I'm sorry I was a little bit late. We had two things to speak at before we were able to come to committee. I have quickly read what I missed.

My question to you is regarding the interim suspensions. The legislation says: "may revoke, suspend ... a licence." You're going to use this as an—on each basis? It's not going to be across the board that everybody who has a complaint against them automatically loses their licence? Or is this, as you said here in your statement—basically, if there are charges or if it's someone who's repetitive or is a danger to the patients, then you'll use that?

Ms. Megan Sloan: Sorry. You're referring to the interim suspension?

Mr. Jeff Yurek: Yes.

Ms. Megan Sloan: Currently, the Inquiries, Complaints and Reports Committee would receive the information and be able to assess, as a panel, each case on an individual basis. Right now, if we receive information that poses a high risk and it meets the legal test—we are restricted from ordering an interim suspension. So, yes, our intention would be to use it, certainly, on an individual basis and only when that legal test is met.

Do you have anything to add, Kevin?

Mr. Kevin McCarthy: The only thing I'd add is that the threshold is currently in effect. The committee may know that when the ICRC is referring to discipline currently—that's used judiciously and if there is really an assessment of likelihood or of risk to the public. I think we recognize—from some other presenters—that there's a concern that that could be used unduly. What's new here is not the ICRC's ability to interim-suspend or to impose restrictions; what it will allow is for the committee to do that sooner. But it's the same test: if there is a likelihood of harm or if there is present harm.

Mr. Jeff Yurek: We've heard from other colleges that the definition of "patient" varies from college to college. You believe there's a better way to word this in the legislation so that we get it right, so it fits each college?

Ms. Megan Sloan: Actually, we use the term "client"—and Kevin might be able to speak to more specifics. But the definition that is used is, any person who enters into a therapeutic nurse-client relationship, who has any interactions with a nurse. It's left intentionally broad, because there's a broad diversity of patients out there, so that you're not restricted and it doesn't—

The Chair (Mr. Monte McNaughton): I'm sorry to cut you off.

We're going to move to the third party. Madame Gélinas.

M^me^ France Gélinas: My questions are along the same two lines of questions that he had.

The comments that you made about earlier interim suspensions—so it will be the same process to determine if a suspension; it's just that the committee will be allowed to do that sooner. Will the nurse have any recourse if he or she disagrees with that decision? How will that work?

Mr. Kevin McCarthy: I think it is the exact same process, but it allows the ICRC to take this action throughout the investigation and referral process. If I recall correctly—I can double-check—that would require that the committee give notice to the member so the member has the opportunity to respond to that before that order is enacted.

Just to put a fine point on it: I think it is the exact same process; it's just allowed throughout it and not only at the later referral-to-discipline stage. Again, the threshold is that there's a compelling public safety issue.

M^me^ France Gélinas: But if a nurse disagrees, he or she, through their lawyer, could still let you know that they disagree and appeal it, the same that they do at any other stage?

Mr. Kevin McCarthy: Yes.

1240

M^me^ France Gélinas: Okay. I just wanted to make sure. Have you had a case where you've had to discipline and take away the licensing privileges of a nurse, based on a case of sexual misconduct?

Ms. Megan Sloan: There have been cases. We don't have exact numbers with us today, but we'd be more than happy to provide that information. We do have available on our website our patient/client relations report, and that lists any sexual abuse cases dating back to 2011.

M^me^ France Gélinas: Okay. The definition of "patient": I know the different colleges work together. The CPSO had put forward 10 or 11 points to define "patient," rather than solely the one year. Did you have a chance to look at what the CPSO put forward, and would that work for you?

Mr. Kevin McCarthy: Yes, we have looked at the submission, but we recognize that the college's current expectations of nurses are different. For example, if it's a therapeutic nurse-client relationship, our current standard says that you can't enter into a personal or sexual relationship with a client until after one year. I know that there has been discussion about episodic care, but our standards require—and that's in our submission as well—that it doesn't matter what the length of time is. Once you engage in a therapeutic relationship, all professional standards are in effect.

The Chair (Mr. Monte McNaughton): Thank you very much. We're going to move to the government, and Ms. Wong.

Ms. Soo Wong: Before I ask the witnesses the question, I want to be on the record that I am a member of the College of Nurses. I just want to make sure everybody knows.

I want to ask specifically, Ms. Sloan, with regard to your presentation today in terms of Bill 87, how you see it from the College of Nurses' standards. What, in your opinion, would the increased transparency and strengthening the whole issue of sexual abuse provisions—you made some references on page 2 in your written submission. Can you elaborate a little bit further? Because you said that right now, if we pass this legislation, it will give you more authority. Can you elaborate on that, under the understanding of transparency and the piece about strengthening the sexual abuse provisions?

Ms. Megan Sloan: One thing that we recognize is that Bill 87 will increase public awareness around sexual abuse as well as boundary violations.

Also, in terms of transparency, right now we are restricted in the information that is given out to the public, so if there's a nurse who is being investigated, we're not able to disclose that information readily. The public expects that. The public has changing expectations.

Those are two things I can think of.

Mr. Kevin McCarthy: The only thing, maybe, that I would add is that a number of colleges are providing the public with more information about their professionals—in this case, nurses.

But just going back to the ability of the ICRC to suspend with high-risk cases, the college believes that that will benefit the public. As it relates to serious matters, including sexual abuse, there would be the ability to meet the public's expectation that the college would be able to impact somebody's ability to continue to practise.

Ms. Soo Wong: Thank you very much.

The Chair (Mr. Monte McNaughton): Great. Thanks for your presentation today.

Ms. Megan Sloan: Thank you.

Mr. Kevin McCarthy: Thank you.

SENATOR MARILOU McPHEDRAN

The Chair (Mr. Monte McNaughton): Now I'd like to call upon Senator Marilou McPhedran, please. Good afternoon, Senator.

Senator Marilou McPhedran: Good afternoon.

The Chair (Mr. Monte McNaughton): You'll have six minutes for your presentation. Questions this time will begin with the third party.

Senator Marilou McPhedran: Thank you. First of all, I want to express appreciation to Dr. Eric Hoskins, the Minister of Health and Long-Term Care of Ontario, for taking the initiative in December 2014 and beginning the independent task force on sexual abuse of patients and the RHPA.

I want to also acknowledge that my co-panel member for the task force, Sheila Macdonald, a registered nurse, manager and long-time practitioner in countering sexual violence, was here before you. I won't repeat what Sheila said; I've gone through the transcript and I endorse all of her points.

I think, though, I'll just quickly point out to you key aspects of the final report, and then I would like to speak for a moment about why I think that, as difficult as it is to climb the ladder that you're all climbing—you're doing very dedicated, very sincere work—the ladder has been put against the wrong wall. It's not going to get you to where I think people want to go in terms of the protection of patients.

That has a great deal to do with the fact that Bill 87—and I see that there's an adoption in Bill 87 of a number of our recommendations. The truth is that the most bold and the most necessary recommendations for deep systemic change have been ignored. I know that Sheila Macdonald used the term "tinkering" when she was here before you. I won't repeat that. But I will ask you to bear in mind that the report To Zero, which was released after extensive legal wrangling, I would have to say, is one that has not been widely distributed. I'm just going to ask for a quick show of hands. How many of you on this committee have read the report? It's available sometimes on the ministry website. It has not been widely distributed.

The point I want to make about this is that the first task force that I was asked to chair was in 1991 and there was an NDP government. The second task force I was asked to chair was in 2000-01 and there was a Conservative government. And the third task force that I've been asked to chair, that I'm here to summarize and discuss with you, was with a Liberal government. So my comments are not about a particular party in power. My comments are more about how government thus far has failed utterly to invest in the people of this province.

Is there anyone here in this room who would consider themselves not a patient? We are all patients. This is a matter of public safety. Patient safety is public safety.

I do applaud the approach of Bill 87 in taking an omnibus approach to looking at the protection of patients, but unfortunately, in terms of the sexual abuse of patients, the adage "If it ain't broke, don't fix it," does

not apply here. It is broke and it does need to be fixed, well beyond what you're seeing with Bill 87.

I appreciate that you're well into the process. I appreciate that, in essence, what has happened with Bill 87 is a decision, and I respect the right to make that decision and the expertise of certain kinds that has been put into the process.

I would ask you, please, just to take a quick look at this diagram that I am presenting. It's in the report To Zero. The report is only available on the website of the Ministry of Health. In this report, what we're trying to convey is that if you take a human rights approach to the sexual abuse of patients, you end up in a very different place. You end up putting your ladder against a very different wall to reach the destination that I know you're all committed to reach.

There's a huge disconnect in Ontario and across Canada in terms of the way in which governments allocate resources in order to invest in the health of all of these sectors.

Where Bill 87 has most dramatically failed is in two key areas: the societal level—we are all patients; public safety is patient safety—and in the organizational level. I have noticed in the transcript of a number of the testimonies prior to my being here today that, by and large, the health regulatory professions are more often supporting changes than not. That makes complete sense, because they get to continue to control a system that is not serving the patients—

The Chair (Mr. Monte McNaughton): Thank you very much, Senator. We're going to begin questions with Madame Gélinas.

1250

M^me^ France Gélinas: Continuing on your train of thought, the report makes it clear that the discipline committee should not be left with the individual colleges. Is this what you would like us to put in as an amendment?

Senator Marilou McPhedran: That's right. If we don't get away from this practice of being investigator, judge and jury, we are not going to have a shift in focus to public safety and patient safety. We have more than 20 years of evidence to demonstrate that to us.

M^me^ France Gélinas: What would it look like?

Senator Marilou McPhedran: It would look like a body very much like is described in our report in 2000 and, again, a modification of that, in the report that was just released this past year. There needs to be representation of all of the health regulatory professions. This is not about shutting them out. But it should not be controlled college by college by college. This is an industry, and we need to dismantle this industry in the public interest. There needs to be an independent body. There needs to be independent investigation and support to complainants who come into the system.

We don't have to really worry to the same extent about health professionals and support to health professionals, because they all have their organizations and they have, in many cases—the Ontario Medical Association being the best example—where fees are actually gathered to sustain the organization. They have defence funds or they are covered by insurance plans.

There isn't a presence of patient advocates before you. Even the few patient advocacy organizations that exist do not deal, for the most part, with this issue.

M^me^ France Gélinas: Why do you figure it's not there? You had made it clear in your report that you were recommending it and it's not there.

Senator Marilou McPhedran: It's not there because government after government after government in Ontario refuses to invest in patients, in patient advocacy organizations, in organizations that exist to look at violence and to develop specialization—to fund specialization with Ontario Legal Aid, for example, to make it possible in the clinics all across this province for people with expertise to be able to actually represent patients.

M^me^ France Gélinas: But this would not be paid for by the government. This would be paid for by the colleges. No?

Senator Marilou McPhedran: Our proposal is that it should be woven into the legal aid plan, because we are all patients.

The Chair (Mr. Monte McNaughton): Thank you. That's all the time for questions from the third party. We'll go to the government: Ms. Wong.

Ms. Soo Wong: Senator McPhedran, you and I go back many, many moons, so thank you for being here and giving up your time to be here from Ottawa. I want, on record, to thank you for your leadership, whether it's in law, medicine, health care. I just want to be on record on that piece.

I just want to verify what I heard you say. You were saying that on this particular bill you want to push us to do more—

Senator Marilou McPhedran: Yes.

Ms. Soo Wong: —in terms of patient advocacy. To verify what I heard, you want a stand-alone body to review, to examine and to discipline any members of the RHPA.

Senator Marilou McPhedran: Yes. We have recommended strongly that there be a central, independent body with representation from all of the health professions, but not in the majority and not controlled college by college by college.

Ms. Soo Wong: The next question I needed to ask you is: Have you consulted the stakeholders, meaning the patients? Because I hear your advocacy, where patients are at the centre. Have you consulted the patients—Ontarians, I would say—about this type of model? Are there any other similar models like this across Canada, Senator?

Senator Marilou McPhedran: No, there are not, but Ontario has been the world leader on this issue. It has stepped forward since 1991. The Ontario system is studied around the world. It's time for Ontario to continue to be the leader and to make this change.

Ms. Soo Wong: So your advocacy is that we want a stand-alone for this province. How about other countries? Are they doing the same? Like, the States or elsewhere?

Senator Marilou McPhedran: No.

Ms. Soo Wong: Nobody's doing it.

Senator Marilou McPhedran: No.

Ms. Soo Wong: Okay. It's interesting that no one is seeing your lens, the patient-centred piece.

You mentioned two areas: the societal level and the organizational level. Can you elaborate? When you say "organizational level," what do you mean by that?

Senator Marilou McPhedran: I mean investment in the organizations of civil society, where there should be and can be research and advocacy on behalf of patients in Ontario.

To your question about anyone else in the world: In 1991, nowhere else in the world was the term "zero tolerance" of sexual abuse used. That comes from the first task force that I chaired.

I just came from sitting in the Senate yesterday, dealing with an ethics question of sexual abuse by a senator, who chose—as many health professionals do—to resign rather than go through any further decision-making about his transgressions.

I do quite a bit of work still at the United Nations. The policy for the UN peacekeepers is zero tolerance. It's around the world.

The Chair (Mr. Monte McNaughton): Thank you very much. We're going to move now to the official opposition, and Mr. Yurek.

Mr. Jeff Yurek: Thank you for being here, Senator. Do you have any input on the definition of "patient" and/or the time frame that this bill states before dating can occur?

Senator Marilou McPhedran: Bill 87 has, for the most part, followed our recommendations on that. I think that it's definitely headed in the right direction.

In a general way, the finding that led to our being so specific comes out of cases where there were ways in which college discipline bodies found ways around what the facts of the case clearly indicated: (a) that there was sexual abuse, and (b) there was a relationship that was practitioner-patient.

Just to make this point again about the ladder being up against the wrong wall: You can tinker and make small changes, add a little bit here to this definition, add a little bit here to this procedure, spend a lot of time with lawyers, talking, but you are not going to change what is fundamentally wrong here.

There needs to be conscious investment in Ontario civil society and patients' rights. Why don't we have a patients' bill of rights? Why doesn't it have resources that have come from our public purse, in order to make it possible for all of us in Ontario—all of us being patients—to be able to access organizations with expertise? Why is it that no major research has been done on this issue, not in the academy, not out in the community—because there's been no funding for it—for almost 10 years?

How do you make good law if you don't have the evidence you need and the research? How it is possible that there has been no funding of research in this area? This is not just a coincidence. There needs to be a conscious decision made by those of you in government, please, to change the resource allocation.

I will make a quick reference to testimony by Michael Decter, a former deputy minister, a former chair of the institutes of health research, who pointed out that "The re-victimization occurs when" patients "seek redress or justice and here it's the imbalance that is really striking in terms of access to resources.... Why should taxpayers"— in this case, he uses medical doctors—"support only the doctors"—he's making reference to the CMPA funding, for example—"how is this patient-centred? How is this just?"

The Chair (Mr. Monte McNaughton): And right on time. Thank you very much, Senator, for being here today.

Senator Marilou McPhedran: Thank you.

ALPHA HEALTHCARE

The Chair (Mr. Monte McNaughton): I'd now like to call upon Alpha Healthcare, and a presenter who is no stranger to Queen's Park and committees.

Mr. Gerard Kennedy: Thank you very much, Mr. Chair.

The Chair (Mr. Monte McNaughton): Welcome, Mr. Kennedy. You'll have six minutes for your presentation. Questions will begin with the government.

1300

Mr. Gerard Kennedy: I'm just going to take, hopefully, not any of that time to get a chair I can sit in.

Thank you, Mr. Chair. I'm delighted to be here today as CEO of Alpha Healthcare, and as a former parliamentarian who still cares deeply about quality, accessible and affordable public health care for Ontario residents.

Alpha Healthcare is a same-family-owned enterprise since 1971. We operate right across the GTHA and in communities like Welland, Erin and London.

I'm here to talk to you about our primary activity, which is community medical laboratory testing, and how Bill 87 should affect the provision of services that we do for Ontario patients in order to protect those patients.

Mr. Chair, did you know that laboratory testing is the second most frequently accessed medical service by community patients in this province, after visits to family doctors? Or that over 70% of all medical decisions depend on the outcomes, at least in part, of laboratory test results?

You would think, given how critically strategic this service is, that it would get significant attention. But instead, our community laboratory set-up in this province is out of sight and, frankly, it's broken. It is a non-system that really needs your attention.

It's broken because it rewards the private companies who provide the service by paying them a fixed market share, regardless of the share of patient service they actually provide, what hours they choose to operate for those patients, or how they decide to interact with either patients or the health care providers that order the tests. The arrangement, simply put, has become antiquated. Despite today's world, with ever-changing technological

and medical knowledge expansion, there have been no significant improvements for our patients in the last 20 years.

To the contrary: During this time, although the population has both grown and aged, bringing with it higher demands on community health care, the number of community laboratory access points has been shrunk significantly. Not a single new test has been approved in Ontario since the year 2000. By comparison, just next door in Quebec, patients there have 34 new tests that have been approved in the last two years alone—better, more accurate and more precise tests that their public health care system offers to doctors to diagnose, monitor and deal with disease.

The community laboratory arrangement in Ontario is not patient-centred. It has become, instead, large lab corporation-focused. Despite the hard work and dedication of all—and I want to be clear on that—of all the front-line staff from all the different organizations that are involved, Ontario patients do not receive the same care and service that other Canadians receive.

What truly and fundamentally defines the widening gap between Ontario and other provinces is a basic lack of public responsibility-taking for access to what has to be considered medically necessary services.

If you had an overview of community testing services, you would see a patchwork of service, varying widely between different regions of the province, not just rural and northern but between and within urban neighbourhoods as well.

Mr. Chair, as one example, the Belleville and Guelph areas have approximately the same service population of about 140,000, but due to a recent closure, the people in Belleville—disproportionately seniors and people with chronic conditions—have only one community lab to attend. Guelph, the corresponding community, has five.

Patients in rural and northern Ontario often have to drive over an hour to access service. Access to community lab service fell by 17% between 1997 and 2001, and another 22% between 2001 and 2009.

The provinces of Quebec and BC have 50% more public patient access centres per capita than Ontario does. Mobility-challenged Ontarians, who were once served at home, are now forced to leave, find transportation and personal support, and then, too often, wait in increasingly long lineups to get service, or even, in some cases, forgo medically necessary tests altogether.

I just want to emphasize that all that service reduction I mentioned was not to create savings for government—not one dime. It was not cutbacks; just companies making choices in a vacuum of fulsome oversight. There is no ongoing input from primary care or specialist clinical practitioners or from laboratory professionals. In fact, the arrangement is now run by officials from the negotiations and accountability management division of the Ministry of Health.

There are no set standards for patient outcomes or patient care. Again, the set-up is non-transparent, so secretive that you, elected MPPs, are not allowed to see which companies receive public funds or how much public funds they are paid to provide these community services to the citizens of Ontario—not at all.

Mr. Chairman, I could go on about how the current non-system fails to serve Ontario patients in the way it can and should, but I want to instead make three positive proposals, quickly, for the committee's consideration.

First, modern oversight: Include an amendment—straightforward—to section 6 of the current act to replace the nominal director with a quasi-independent commissioner of laboratory services with the responsibility to ensure every Ontarian has reasonable access to up-to-date, medically necessary laboratory services, have powers to consult clinicians to ensure patient access and service quality, and publish an annual report to the Legislature on the effectiveness of the system for patients.

Second, please make sure to maintain existing service. Right now, we recommend you amend schedule 2, section 1(6)—

The Chair (Mr. Monte McNaughton): Mr. Kennedy, the six minutes is up. We're going to move to the government and Ms. Wong.

Ms. Soo Wong: Thank you very much, Mr. Kennedy, for being here today. I met with you last week, so I've given your three asks to this committee.

In your first ask, you ask for more modern oversight of the laboratory services in the province of Ontario. Am I correct that your first ask is like an independent officer of the Legislature?

Mr. Gerard Kennedy: Not necessarily. I think it's more like the public health officer—appointed by cabinet, a conspicuous appointment. It still can be integrated with the ministry. But if you look at BC, where they've now got an agency running laboratory services, or you look at most other provinces, you don't have private companies—

Ms. Soo Wong: Okay. I don't have a lot of time, so it's my question, okay?

Mr. Gerard Kennedy: Sorry. I was answering your question, I thought.

Ms. Soo Wong: My question here is, we already have an existing director of laboratory services and genetics. My question to you, through the Chair, is, are you saying that that particular position should be null and void and to restart with, as you called it, a quasi-independent commissioner?

Mr. Gerard Kennedy: All of the powers the director exercises on behalf of the ministers can stay intact, but until two years ago, for 15 years, that was exercised by a career civil servant. No disrespect whatsoever to the wonderful civil service, but it needs to be somebody who has the medical and technical knowledge and someone that has the stature to make decisions, from time to time, to make sure that the government has the best advice possible. That does not exist today, and it hasn't been there for 18 years. It used to be that the same person that ran the public health labs was the director. That was removed from legislation.

Something new, we think, can be done to take full advantage of who you really want there as not just an advocate for patients, but a bit of a referee to make sure

you get the best out of the private companies, which can deliver for you.

Ms. Soo Wong: More time?

The Chair (Mr. Monte McNaughton): Over a minute.

Ms. Soo Wong: Okay, I've still got a minute. Good.

My second question here is with regard to your second ask about maintaining existing services. You ask to "maintain the current exemption allowing doctors and nurse practitioners to supervise" the staff. My understanding is that this already exists in regulations, so how are you suggesting to this committee—

Mr. Gerard Kennedy: With all respect, it doesn't exist in regulation. I think maybe the ministry had said it might put it in regulation, but—it's a sensitive kind of thing. Individual doctors and nurse practitioners are providing supervision to their staff. That's an important part of service. They are more than qualified to do that; there's no risk to patients.

If, however, it's a large clinic or office and we're providing the staff, then we're saying, "Yes, subject us to those regulations because that would be consistent with the public points of access." So it's a distinction that we're saying should be met. Otherwise, you could lose up to 15% of the service that there is if—and I'm not saying they would necessarily, but in past years, people have dropped services when regulation became too onerous and so on, because it's taking blood and it's handling specimens, and a lot of offices have stopped doing that.

Ms. Soo Wong: So my understanding is that with the proposed amendment—

The Chair (Mr. Monte McNaughton): Ms. Wong, that's all the time. We're going to move to Mr. Yurek.

Mr. Jeff Yurek: Thanks, Chair. Thanks, Mr. Kennedy, for being here today. It's not often we get a company here at committee that has been in existence longer than Jim Bradley has been an MPP. So it's good to be here.

Mr. Gerard Kennedy: I'm not sure how to take that, but thank you.

Mr. Jeff Yurek: You raised an interesting point here that I just wanted you to touch upon perhaps. I've been a member since 2011. Every year, I've had conversations with the different lab companies on the fact that the agreement is still in the works to have a long-term agreement with these labs. It's interesting that you note that no new tests have been approved since 2000. Is that tied to this problem of actually achieving an agreement with the labs?

Mr. Gerard Kennedy: No, I don't think it's the agreement, nor should it be. We're service providers, and I think the government has spent a lot of time talking to labs. They should be talking to the nurse practitioners, to the physicians, to the patients. As we heard from the previous deputant—I mean, patients are a big, big part of this equation. Five per cent of patients use 35% of the testing services. It's a big part of their life.

1310

The problem has been not having a framework to work in. There hasn't been a contract; that's a separate thing. I think we're going to see regulations about that. The government, to its credit, tried some things between 2011 and 2015, and, for example, brought back 40 offices that had been closed, 88,000 new hours. Since 2015-16, we're kind of in a grey zone. We don't know what's happening next. We think improving this act, which I think the government referred to more as housekeeping, would really help the other measures the government could bring forward at this time.

Mr. Jeff Yurek: Will you read your final recommendation into the record for us?

Mr. Gerard Kennedy: Sure. The third recommendation is just to ensure patient choice for better service. We're the only province in the country that has only private companies providing the service. We support the amendment that brings hospitals back in, and hopefully the not-for-profits that have done a really good job brokering tests as well and supporting our public infrastructure.

We're talking about schedule 2.2, which replaces the current section 9 with a new section 9. In the new section, we're saying to remove subsection (7). This would enable patient choice and innovation at no additional cost to the public by ensuring service location growth can match real-world patient need. It would end an unneeded ministerial discretion over the number and location of the collection centres, the places where people go either to drop off urine or to give blood, based on artificial criteria. In practice, only openings have been prevented, while there are no restrictions on closings. The public interest is not served if we can't provide new locations where they are needed.

The Chair (Mr. Monte McNaughton): Excellent. On that note, we'll go to Madame Gélinas.

M^me^ France Gélinas: Thank you so much. What you talk about is a reality in my riding. You and I have talked, and I've talked to other labs. There used to be a collection service in Hanmer; there isn't anymore. There used to be one in Chelmsford that doesn't exist anymore. I can name pretty well 33 communities in Nickel Belt that used to have specimen collection, lab people there to draw blood. They don't exist anymore. Everybody has to drive downtown to the lab. This is not patient-focused. Now we see more and more extra charges. If you're not able to drive to the lab in Sudbury, yes, they will come and draw blood at your house. But you have to pay, which means, for a lot of Ontarians, they go without.

You've put three recommendations forward that more or less fit into the bill. I've looked at the interaction you've had with the Liberal member in order to open to it. Why would that be? The solutions you've put forward are to improve access, to make it patient-centred and to bring oversight, yet we see reluctance from the Liberals to do this. What am I missing?

Mr. Gerard Kennedy: Again, I want to give the government credit for having taken a fair bit of effort between 2011 and 2015. Of all the ministries I never wanted to have, health was high on the list. It is important, though. This is the only time this has been raised in 18 years. The government will own the policy going

The Chair (Mr. Monte McNaughton): Thank you, Mr. Carson. We're going to move now to the government and Ms. Kiwala.

Ms. Sophie Kiwala: Thank you, Mr. Carson, for being here today. It's a pleasure to have you here. We know—and I know you know—that the amendments that have been brought forward through Bill 87 are intended to be modernizing and improving the laboratory sector. You said that the devil is in the details. I'm wondering if you can speak a little bit to the details and how the changes, the amendments, will improve the efficiency in the sector.

Mr. Chris Carson: Help me a little in what part of efficiency you'd be referring to.

Ms. Sophie Kiwala: Well, because it's your industry, I'm going to let you speak. Assuming this goes forward and this bill is passed, I'm wondering if you can speak to, once you see those provisions coming into place, how those provisions have the potential to create efficiencies in the system.

Mr. Chris Carson: Okay. I would say that our view is that there is a lot through the amendments to the legislation that is enabling a lot of reform that the ministry is undertaking through policy as well. I would say that in providing value there are a number of steps towards accountability. There are also a number of things in the model that will incent towards access.

I think part of our point has been that now moving towards a competitive funding model, it's important that the rules that are established for that are actually supporting the kind of appropriate access we want to see and that is ensuring that value is still going to quality as opposed to just more costs that are not benefitting patients. I think the ministry has been very alive to that, and I think there's still opportunity to get there, but it's critical to the viability of continuity of service and quality.

Ms. Sophie Kiwala: Okay. Thank you.

The Chair (Mr. Monte McNaughton): Thanks for your presentation today.

ONTARIO MEDICAL ASSOCIATION—SECTION ON GENERAL AND FAMILY PRACTICE

The Chair (Mr. Monte McNaughton): I'd like to call upon the Ontario Medical Association—section on general and family practice. Good afternoon. If you'd each state your name for Hansard, please, you can begin with your six-minute presentation.

Dr. Ross Male: Thank you, Chair. My name is Dr. Ross Male. I'm chair of the OMA section on general and family practice and a family doctor from Paris. With me are Dr. Asad Razzaque, vice-chair of the section and a family doctor from Stoney Creek, and Ms. Kathy Bugeja, our strategic consultant. We appreciate the opportunity to address this committee regarding Bill 87.

Our section is the largest clinical section of the Ontario Medical Association and represents over 12,000 family doctors in Ontario. Because of the perceived implications of Bill 87 on the fundamental clinical care that Ontario's family doctors provide every day to 155,000 patients, we've conducted considerable due diligence to understand the nuances of this bill and separate fact from fiction so we may best inform government on what key areas they may want to consider changing prior to third reading.

1330

Let us begin by affirming that Ontario's family doctors want to practise in a safe and respectful health care system where there is zero tolerance for sexual abuse of patients and where offenders are swiftly dealt with in a fair application of college rules.

We recognize that the government's actions to review and modernize the current Regulated Health Professions Act through Bill 87 are a patient safety strategy. We also recognize that the health professions procedural code, which is schedule 2 to the RHPA, very clearly defines what constitutes sexual abuse as well as the conditions and processes by which the college's Inquiries, Complaints and Reports Committee may issue an interim suspension order and/or refer matters to the discipline committee. The problem is that the majority of the public, including our own members, are unaware or unfamiliar with the intricacies of the RHPA, and as a result a variety of interpretations have arisen which have caused confusion and apprehension amongst our members.

I'm talking in particular about that section within Bill 87 which proposes mandatory revocation of licence where sexual abuse of a patient consists of "touching of the patient's genitals, anus, breasts or buttocks." Our members are thinking of any touching, even though the code lists the exception that "'sexual nature' does not include touching, behaviour or remarks of a clinical nature appropriate to the service provided." Unfortunately, this exception is neither obvious nor easy to find for our members, which makes them jump to conclusions that Bill 87 also encompasses the fundamental clinical care they provide every day.

Let's correct this misinterpretation now. We want and need Ontario's doctors to practise to their full scope. We do not want the delivery of patient care to be compromised due to a lack of expert knowledge of the RHPA. Therefore, we propose the following simple solution which we believe will greatly allay our members' apprehensions: Reiterate what we see in the code within the substitution being proposed by Bill 87 under subsection 51 such that it would now read, "Touching of the patient's genitals, anus, breasts or buttocks in a manner that is not of a clinical nature appropriate to the service provided."

Dr. Asad Razzaque: Mr. Chair, my name is Dr. Asad Razzaque.

As it currently stands, Bill 87 will require physicians to submit personal health information to the CPSO which could then be reported to the ministry. It's unclear how granular the level of detail provided will be, whether the information is de-identified, who else will have access to

it and whether there is a statute of limitations after which time the information will be deleted from government files.

We are astounded that Bill 87 will create two-tiered patient rights whereby the privacy rights of non-physician patients are protected and enshrined in legislation, while physicians who are patients have absolutely no privacy rights. This seems to us to be a PHIPA violation. Physicians are Ontario citizens who should be afforded the same privacy rights as the rest of Ontario's population. We are concerned that if Bill 87 passes, however, physicians won't seek help for fear of having their personal information potentially exposed for anyone to see.

With respect to posting of matters on the college register, notwithstanding that orders made by the ICRC, such as oral cautions, specified continuing education and remediation programs and undertakings are already posted on the college register as per CPSO bylaws, we still take issue with Bill 87 proposing that they should be posted indefinitely on the public register. Often, these aren't on the same level as disciplinary committee findings related to professional misconduct. For this reason, we believe a statute of limitations should apply here and that this information should be removed from the register within an acceptable time frame that is established by the CPSO.

Bill 87 proposes to give the minister significant regulation-making powers on how college committees and panels will be composed. Courts have recognized that self-regulated professionals are best suited to determine whether a member has engaged in professional misconduct. Given the importance of the decisions made by the committees and panels of the colleges, it is essential that the professionals involved are entitled to a high standard of procedural fairness, including the right to an impartial decision-maker, judgment by one's peers, and a transparent process. If the minister can decide the composition of committees, this raises serious questions about their impartiality and transparency.

Proposed amendments to the Immunization of School Pupils Act shift more of the responsibility of reporting immunizations from parents to the administering physician. We understand that Public Health has presented before the committee and recommended that this amendment be deferred until the appropriate technology is in place and operational to execute this part of the bill.

We would agree with this suggested deferral, as this would also give the ministry and the profession the requisite time to explore the associated workload expectations of physicians and required supports—

The Chair (Mr. Monte McNaughton): Thank you very much. The six minutes is up. We're going to begin questions with the third party, and Madame Gélinas.

M^me^ France Gélinas: I would be okay to let you finish, if you want.

Dr. Asad Razzaque: I appreciate that. There is one final issue that we would like to address before the committee.

Regardless of how well family doctors adhere to good clinical practices, more and more of our members are experiencing situations where patients, unhappy with their demands not being met—and opioid requests are prominent here—are resorting to threats and blackmail. At present, patient confidentiality and various policies limit physicians' access to the same legal remedies that are available to other Ontario citizens. We need to address this imbalance of rights, to ensure both physicians and patients are protected.

In the final 20 seconds: In closing, Ontario's family physicians want to ensure both patient and provider rights are protected moving forward. We are happy to work further with you to ensure this unfolds properly, even if it means deferring portions of this proposed legislation until we arrive at a mutually acceptable solution which will benefit both patients and doctors.

The Chair (Mr. Monte McNaughton): About a minute and a half.

M^me^ France Gélinas: My first question is: How much was the OMA consulted before those two parts of the bill were brought forward?

Dr. Ross Male: I think the OMA was not officially consulted before the bill was released. Obviously, there have been some discussions since then, but it's more on a case of as we've presented before the committee and to individual MPPs.

M^me^ France Gélinas: Okay. I can ensure you that you'll have my support when it comes to personal health information being disclosed to the ministry. I am opposed to this. We cannot create peepholes inside of FIPPA, because then the trust is broken, and nothing good comes of that. I will try to support you like I did in the previous bill, to make sure that it doesn't happen. I did not get any support from the Liberal side, but it is still the right thing to do.

A change of topic: What the college is telling us is that if the college is given the right to post the matters on their registry, this will help to protect the public. You're saying that this will be more damage than help.

Dr. Asad Razzaque: If the member is, in fact, found innocent, what you'll have is an item on the registry which shows that a physician was accused of something and then subsequently found to be innocent. But if there is an indefinite period of time, that member has their professional reputation tarnished in that community, and it's difficult for them to carry on work within that community.

The Chair (Mr. Monte McNaughton): Thank you very much. We're going to move to the government now, and Mr. Fraser.

Mr. John Fraser: Thank you very much for presenting today. Dr. Male, we've had a chance to meet before on Bill 41.

Dr. Ross Male: Yes.

Mr. John Fraser: Dr. Razzaque, I think we've had a chance to meet before.

I want to thank you for your presentation. It was very clear. We have heard some similar themes in other presentations. I was at an OMA event on Saturday night,

and a number of people came and talked to me about that, so I heard that very clearly. I know there is work being done right now with the ministry, working back and forth, taking a look at certain things.

I wanted to talk to you about a certain provision in the bill that did not come up in your presentation, and that is the support for those people who are affected by sexual assault. I think that's critical. I believe, and I think most of the members in this committee believe, that that's critical, to get that early support. I just want to know if you have any thoughts on that. Any thoughts on that in the bill?

Dr. Ross Male: It is critical to give support to the patients who have been affected that way, because we have seen in our own practice that when someone is subjected to sexual abuse, it really affects their life for a long time. The earlier you can intervene properly, the better it's going to be for them. So that is certainly critically important.

It's also difficult because, in many cases, the person the patient might tend to turn to for that care is the person who abused them.

Again, it's a very difficult situation. We need to give those patients as much support as we can.

Mr. John Fraser: Thank you very much.

Dr. Asad Razzaque: If I might add—we have a universal health care system, so if a patient has been traumatized, I would like to think that our system will be robust enough to support those patients while the process of investigation takes place.

1340

I would gather that once the investigation has come to its conclusion and findings have been made, then there would be an award made to the patient for any subsequent psychological counselling which that patient may need.

Mr. John Fraser: Okay.

The Chair (Mr. Monte McNaughton): Thank you very much. We'll move to the official opposition, and Mr. Yurek.

Mr. Jeff Yurek: Thank you for being here today. I want to comment that I do support your appeal for restricting personal health information access by the government. We've seen an erosion of this since Bill 119, Bill 41 and now Bill 87, each creeping into people's personal health information. Now it has reached health professionals. This type of intrusion into the privacy of people has to stop.

I want you to comment on the fact—and I'm hearing both sides of the story with regard to the interim suspension that the complaints and reports committee may issue. There's a fear out there from doctors that that's going to apply to everybody. Have you heard that? What are your thoughts on that?

Dr. Ross Male: Certainly, it's a fear we've heard from our members. As I said, we did our due diligence, looking into what actually happens in those processes. We think it's a little less of a scary likelihood than initially everybody thought, looking at it.

The complaints committees do have to do a proper investigation, and they would do a sufficient investigation before they would offer an interim suspension. The only thing that may be missing is the ability to appeal that interim suspension to the Health Professions Appeal and Review Board. We want to make sure that is there in the processes, since this is also a new capability we're giving to the ICRCs.

Mr. Jeff Yurek: Okay. Your recommendations here are basically just trying to be more specific with regard to sexual touching and such.

Dr. Ross Male: Exactly.

Mr. Jeff Yurek: And you're totally supportive of zero tolerance.

Dr. Ross Male: Very much so.

Mr. Jeff Yurek: Okay, that's great.

The Chair (Mr. Monte McNaughton): Great. Thanks for your presentation today.

IN-COMMON LABORATORIES

The Chair (Mr. Monte McNaughton): Now I'd like to call upon In-Common Laboratories. Good afternoon.

Ms. Kris Bailey: Good afternoon.

The Chair (Mr. Monte McNaughton): You'll have six minutes for your presentation. If you'd state your name for Hansard to begin. Questions this time will begin with the government.

Ms. Kris Bailey: Good afternoon. My name is Kris Bailey. I am the CEO of In-Common Laboratories. We are the only private, not-for-profit laboratory in Canada and, obviously, in Ontario as well. We have a registered status in all provinces and territories for laboratory testing, which is unlike any of the other laboratories that exist in the country.

We are the oldest lab in Canada as well; we're celebrating 50 years this year. We provide services to hospitals, clinics, private labs and approved practitioners.

ICL does not perform testing. We act as a broker and a one-stop shop for anybody needing lab testing, and that includes the hospitals, clinics, practitioners etc. We support and leverage the power of the public sector as reference laboratories.

We support the legislation's goal of ensuring high-quality and timely lab services in all parts of the province. Access to caregivers and to patients closer to home is what we support.

Through Bill 87, the Ministry of Health and Long-Term Care has the opportunity to learn from failed previous attempts. This legislation meets the current and future needs. Benefits to the health system include the following: Lab tests comprise 85% of objective data on a patient's chart, so caregivers can make good patient decisions. A $3-to-$25 lab test can save the health system millions of dollars in downstream costs if provided locally. Geography does not and should not determine where lab services can be accessed. Profitability should not determine where lab services can be accessed.

This legislation allows ICL to work with hospitals to provide testing for local communities by utilizing spare

capacity close to home, by maximizing the use of existing public resources for local testing by the hospital and collections by In-Common Laboratories. This opens the opportunities for different places of specimen collection versus the traditional bricks-and-mortar-only solution.

This legislation modernizes and transforms the service of lab medicine for caregivers and patients in hospitals, in rural areas, in the north and also in urban areas. There are at least 60 identified communities where improvements can be made—better medicine, better patient outcomes. This sets the stage for further refinements to the delivery of lab medicine, such as point-of-care testing in the outpatient environment.

ICL supports the public health system and believes that this legislation enables the right tenets of health care affordability and access to be achieved. Licensed service providers that do not test, such as ICL, should be given separate consideration, based on oversight and logistics management skills, to handle the collection of specimens and management of referral testing, including genetics.

As a final comment, regulations enabled by the legislation governing the promotion and advertising of laboratories—should not be able to claim superiority, nor criticize other labs, potentially undermining public confidence. Thank you.

The Chair (Mr. Monte McNaughton): Thank you very much. We'll begin with Ms. Kiwala.

Ms. Sophie Kiwala: Thank you very much, Kris, for being here today. That was a great presentation. It's clear from your presentation that you're very committed to health care. And happy anniversary on your 50th.

Ms. Kris Bailey: Thank you.

Ms. Sophie Kiwala: That's a great level of experience behind you.

I want to explore in a little further detail and just address the delivery challenges that we're faced with in the north and rural communities in the province. Obviously, our interest is in ensuring that all Ontarians have access to high-quality laboratory services. I'm wondering if you can dig a little deeper and provide us with some advice on how we can improve access to high-quality laboratory services in rural and northern communities.

Ms. Kris Bailey: Thank you for that. It's certainly a strong interest of mine and a passion—that, regardless of where you live, you should be able to get access.

In the current system, some hospitals provide specimen collection and testing for patients in the north and rural areas. They are not paid for this testing, so it comes out of their hospital global budget. The private lab sector, on the other hand, under the same circumstances, can operate in various communities and be paid for those services, but because they're for-profit laboratories, they make business decisions about where they locate.

In-Common Laboratories was set up by the government early in 1967 to deal with the downtown Toronto hospitals, because they didn't like talking to each other. Nothing much has changed over 50 years. They still don't like talking to each other, right across the province. So we acted as the buffer, the mediator and the broker between them. I think we bring an incredibly different perspective, different business model of working with hospitals, with private labs, with people, to put the glue together. I think Chris Carson made it pretty clear that no one size fits all. I think about other options like bringing the mobile buses to the table, a different vehicle by which to enter communities that don't have a lot of volume but have need. There are just so many solutions that can be targeted in various communities across the province. It doesn't need to be the same solution.

The Chair (Mr. Monte McNaughton): We're going to move to the official opposition: Mr. Yurek.

Mr. Jeff Yurek: Thanks for being here and bringing your model to committee. It seems like the way that In-Common Labs operates would be beneficial to rural and northern parts of the province where—the member of the third party has mentioned that her constituents have to travel quite a distance. Is that true? Do you fit the urban area as well?

Ms. Kris Bailey: We can, but I don't see where a company that is not here to compete with the large private labs but to fit in where the need is the most—and consequently, the north, the rural areas, and working with local hospitals is our model. We'd like to see in the small towns, small hospitals that they stay vibrant, that they can cover a 24/7 operation and that they can serve their communities well.

So, in answer to your question, the north and the rural areas and the real—I would say small-town Ontario is really where our interest lies. We work with the big academic centres in all hospitals across the country, moving samples back and forth, because no lab does everything—no one.

1350

Mr. Jeff Yurek: It's interesting. We've had three different models thrown at us today. Nothing like adding confusion to the discussion. We have the smaller companies asking for more competition, the ability to compete and grow. The larger companies are asking for different rates to be applied in the underserviced areas to promote their growth into those areas. And you are looking to work as a partner, I guess—you say "broker"—utilizing our hospitals and public sector labs to grow.

Ms. Kris Bailey: Correct. You know, I'm not keen on—we are in the not-for-profit world; let's face it. Medicine is not a for-profit business. Everybody deserves to have access. Consequently, more competition is not necessarily what I would promote, but certainly having options on service delivery models, I think, is a good way to go.

Mr. Jeff Yurek: Thank you.

The Chair (Mr. Monte McNaughton): Thank you. Madame Gélinas?

M^me^ France Gélinas: So where in the bill do we put that in? How does that happen?

Ms. Kris Bailey: Well, we have been discussing with the lab and genetics branch on a fair number of occasions

about how to build flexibility into this. To be honest, I really don't know. I think there has to be something to open the door in the legislation, but in the regulations is probably where it will be better described.

M^me^ France Gélinas: You saw that there was a suggestion that we appoint a commissioner of lab services to bring more transparency and accountability to the lab sector. Is this something you would support?

Ms. Kris Bailey: I've been around this business for a long time, and I think that having a strong, educated, knowledgeable person who is bipartisan, if you will, across the lab businesses is a very important role. Currently, there is a person who is leading as the director who I feel fits the bill pretty well. But, going forward, and always looking forward, whatever you want to call them, they need to have that transparency and treat everybody as equals regardless of their size or money.

M^me^ France Gélinas: Before that person was there, were you as satisfied with the level of oversight and transparency from the person that was there?

Ms. Kris Bailey: I felt there was a certain level of lack of understanding of the business and a certain level of siding, if you will—I don't know if that's a bad word or not—with the larger, private labs because they could afford to talk to them more frequently in different ways. The hospitals are not very well organized in terms of having a voice.

M^me^ France Gélinas: So it could happen again if we don't put something in place to make sure that we always maintain that competency in that role. I like that.

Do you have any worries at all in the bill for individual physicians and nurse practitioners to draw blood in their office?

Ms. Kris Bailey: I do not.

M^me^ France Gélinas: You don't think that the bill could lead to them having to meet more stringent—

Ms. Kris Bailey: Well, laboratory management inside a physician's office needs to have a certain level of guideline around it, and certification, so that you have people who know how to collect blood or know how to do point-of-care testing. I think that needs to be there, but to have too much oversight just gets to be a bureaucratic nightmare.

M^me^ France Gélinas: Agreed.

My last one is, how do we bring back the collection sites that used to be in the north and have all disappeared?

Ms. Kris Bailey: We are the perfect solution for you, working in partnership with all the little hospitals. We collect and we broker the testing to the local community. They do the tests—

The Chair (Mr. Monte McNaughton): Thank you very much, Ms. Bailey. That's all the time we have for your presentation.

Ms. Kris Bailey: Perfect. Thank you.

The Chair (Mr. Monte McNaughton): Thank you very much for being here today.

ONTARIO HOSPITAL ASSOCIATION

The Chair (Mr. Monte McNaughton): I'd now like to call upon the Ontario Hospital Association. Good afternoon. You'll have six minutes for your presentation. If you would begin by stating your name for Hansard, and go ahead.

Mr. Derek Graham: Good afternoon. My name is Derek Graham. I'm president and CEO of Manitoulin Health Centre, and I'm also a long-serving board member of the OHA. I am joined today by Nicole Haley, the president and CEO of Espanola Regional Hospital and Health Centre. I am pleased to be here today to highlight important considerations regarding Bill 87 on behalf of the OHA and its member hospitals.

We support the government's move to expand the role of public hospitals to enable them to provide targeted community-based lab services in some instances and in some locations. This flexibility would promote better access for patients and sustainability for the system.

When we talk about community-based lab services, we are referring to the lab services that are offered both by hospitals and private labs for individuals within the community. At present, the relatively low number of patients and low volume of lab tests in many of the small and rural communities that we serve make it very challenging for private community labs to operate in a cost-effective manner. There just are not the economies of scale.

In these circumstances, these communities are without local private lab services. As such, it falls to the local hospital to provide not only core lab services for their internal operations, including emergency and in-patient populations, but also lab services for residents in the community. Without the hospital, there would be no local access for these needed services in many circumstances.

In other settings where private community labs may operate, their hours do not always coincide with those of other health care providers, such as the local family health teams. In these cases, when an urgent test is ordered, it ends up being sent to the hospital for stat turnaround.

These services are both provided and paid for by the hospitals through their global budgets. Hospitals in rural and underserviced areas assume the costs for providing this service to residents in the community without receiving dedicated funding or proportional reimbursement for the work. This strains hospital resources and takes away from hospitals' other priorities.

Enabling hospitals to provide community-based lab services along with their core internal volumes can create relatively stronger local economies of scale to ensure the appropriate resources are in place, like state-of-the-art analyzers, and expert technologists and pathologists. It also consolidates the information and the test results within the hospital's information system. This provides a single point of access for patients and can improve clinical interpretation of results.

Allowing hospitals to provide community-based lab services and remunerating them appropriately will ensure

that patients can continue to access essential lab services close to home. It will also provide the hospitals with much-needed resources, alleviate cost pressures and contribute to sustainability for small and rural hospitals, particularly in the north, through appropriate funding.

Now I'd like to turn it over to my colleague Nicole Haley, who will speak to some other important considerations.

Ms. Nicole Haley: Thank you very much, Derek.

Another key issue addressed in Bill 87 is the significant changes to the Regulated Health Professions Act. Hospitals have zero tolerance for sexual abuse and work very hard to provide a safe place where patients can get the care they need. As such, the OHA supports the implementation of more rigorous safeguards that will help protect patients from sexual abuse.

There are many positive aspects of this legislation, but it will be important to ensure that the intent and the impact of the bill are well communicated and that health professionals are engaged. In our experience, all stakeholders—the colleges, health care professionals themselves and employers like hospitals—must work together to address this issue, improve patient care and maintain the public's trust.

We also believe there is an opportunity to ensure that institutions where regulated health professionals work, like hospitals, have the necessary information to make informed decisions about how to best ensure the safety of their patients. For some time now, the OHA has advocated for changes that would allow regulatory colleges to share information with hospitals regarding professional practice issues for regulated health professionals. While Bill 21, the Safeguarding Health Care Integrity Act, amended the Regulated Health Professions Act to permit this kind of information sharing, a further regulation is needed to operationalize this authority.

We strongly encourage the government to move forward with these regulations to ensure that colleges are able to notify hospitals when issues or concerns regarding any of their members may impact patient care. Hospitals may not always know when colleges investigate or make decisions regarding a health professional. As you can appreciate, it is critical that hospitals know when issues affecting patient care arise so that they can be appropriately managed. We look forward to ongoing collaboration with the government and other stakeholders to address this critical issue.

Thank you very much for your time. We are now happy to take questions.

The Chair (Mr. Monte McNaughton): Thanks very much. Questions will begin with the opposition. Mr. Yurek?

1400

Mr. Jeff Yurek: Thanks for being here today. In the last part of your presentation, you talk about being notified. The new regulations are stating that a lot of it is going to be online, but you'd still prefer the college to reach out and let you know what's going on. Do all doctors inform the college of all of the hospitals they're practising in?

Ms. Nicole Haley: That's the thing we need to ensure, that the hospitals where health care professionals are practising—that we're made aware if there are any concerns. As you said, it may be available online but, for example, at a small hospital, we don't have somebody who's checking the online services on a regular basis to see if there's something new.

Mr. Jeff Yurek: But is it collected at the college level, every aspect of their practice? I mean, if the college doesn't know they're working at your hospital, they're not going to be able to notify you.

Ms. Nicole Haley: That's fair enough. I mean, if they don't know—

Mr. Jeff Yurek: Okay, thanks.

The Chair (Mr. Monte McNaughton): Thanks very much. We'll move to Madame Gélinas, please.

M^me^ France Gélinas: Pleased to see you, Derek. Nice to see you, Nicole.

You're in favour of the changes to the hospital labs. I don't know if you've heard, but we've had some suggestions. The first suggestion is that we put in a commissioner of laboratory services, somebody who would make sure that there is accountability and transparency. Is this something that you've thought about, that you would support or have issues with?

Mr. Derek Graham: I think that, directionally, it certainly could be a good mechanism. I also think that the overall design for how the system works is probably more critical, however, than necessarily the oversight. If the correct mechanisms are in place, and the system is built in a way that creates that local access and local accountability and so on, then I think that's less important.

Certainly, from a cost-effectiveness perspective, and looking at where the dollars are being spent within the industry, I think it's important that Ontarians get good value, so I would support it from that aspect, France.

M^me^ France Gélinas: Okay. How confident are you that we will pass this bill, and hospitals will be allowed to—but it would actually really happen that you will get compensated for the community lab that you do, and that you could start to undo the damage of all of the collection points that have been shut down in the north, and the hardship that that causes to people in the north?

Mr. Derek Graham: Right. We're very encouraged that the right mechanisms can be put in place if there's a willingness to do so. Looking at the design from the standpoint of "community by community" makes sense, because each community does have different nuances of services that exist today, as you've heard already from other parties here today.

M^me^ France Gélinas: Have there been any worries from the family health teams that work at your hospital that they will have to meet a higher standard to be able to draw blood in the family health team?

Mr. Derek Graham: We haven't heard that concern, France. In fact, the family health teams in our region are encouraged by this ability, in that they believe there could be expanded access to collection services—again, if it's designed correctly.

M^me^ France Gélinas: And for the sharing of information—when you register with your college, you have to say where you work. For physicians, they would have to say that they have privileges at the hospital.

Mr. Derek Graham: That's right, and that's all part of the credentialing process and the paperwork that flows back and forth between the hospital and the college.

M^me^ France Gélinas: Okay. So you would like information coming from the college that hospitals sometimes—

The Chair (Mr. Monte McNaughton): Madame Gélinas, we're going to move to the government now.

Any questions from the government? Mr. Fraser.

Mr. John Fraser: Thank you very much for your presentation today. I think half of my question already got answered through my colleague's question.

In terms of specifically the amendment that would allow hospitals to receive the same fee structures as community labs, can you speak to how that would help or improve access, from your perspective as the OHA, or maybe specifically where you see that in a certain area?

Mr. Derek Graham: Right now, in many rural and northern communities where the hospital is having to provide the service, they're not only providing the testing itself, but they're also providing the collection service. So they have to find the room within their global budget to pay for the staff to do the collection, and then often for the infrastructure to transport the samples back to the hospital lab to analyze them. In the case where there is an actual revenue stream against that, it would enable opening up hours of service. It would enable opening up additional points of collection in many rural settings.

Also, from the standpoint of providing some revenue against the actual testing, again that frees up global-based dollars to be able to put against other pressure points.

Mr. John Fraser: That's great. Thank you very much.

The Chair (Mr. Monte McNaughton): Thanks for your presentation.

DOCTORSONTARIO

The Chair (Mr. Monte McNaughton): I'd now like to call upon DoctorsOntario. Good afternoon.

Dr. Douglas Mark: Good afternoon.

The Chair (Mr. Monte McNaughton): You'll have six minutes for your presentation. If you'd begin with your name, please.

Dr. Douglas Mark: Thank you. My name is Dr. Douglas Mark. I'm interim president of DoctorsOntario. Since 1996, we have been a voluntary, grassroots organization of front-line physicians dedicated to protecting the rights, freedoms and independence of medical doctors and their patients by promoting sustainable health care policies and practices that safeguard accessibility and high standards of medical care.

I'll be focusing my discussion on schedule 4, amendments to the Regulated Health Professions Act, 1991, and focusing on three issues: Firstly, what's all the fuss? No, I'm not trying to make light of this very serious issue. We all can agree that any act by a physician upon a patient of sexual impropriety or abuse is a serious offence and unacceptable. As a physician, it's truly disheartening to learn when a colleague crosses the line and harms a patient in such ways. It's not our nature, as we are trained to help and not harm. No, my question really asks: Are doctors running amok, sexually abusing patients? And I ask: Is the current legislation not enough to keep careful watch over doctors, protecting patients, and not interfering with our work? It doesn't appear so, based upon the new proposals.

The fact is, the rate at which physicians were found to have harmed patients in this way is exceedingly low. In the 2015 CPSO annual report, there were a total of seven cases out of 34,124 active physicians—a rate of 0.02%. In contrast to that, the Toronto Police Service Annual Statistical Report from 2012 revealed that there were 2,896 reported cases of sexual assault. That works out to a rate of 0.1%—five times higher. For doctors, a rate of zero would be the goal we're striving for, but from what we can see, doctors are not running amok and increasingly sexually abusing patients.

Furthermore, the process in place in the current Regulated Health Professions Act seems both fair and adequate. Tracey Tremayne-Lloyd, a certified health law specialist, who was one of the key catalysts for helping us bring the unjust medical review committee audits to an end, stated, "Under the current legislative regime, the sentence is commensurate with the crime, with the facts of the particular set of circumstances." In other words, if it ain't broke, don't fix it.

My second point is about trust. Patients trust doctors highly as a profession, and we are privileged to have this trust. Patients also have a deeper trust in their own doctors, a trust that is earned over time, that is the foundation of the doctor-patient relationship. As a family doctor for nearly 31 years, this trusting relationship is truly profound, and one we take exceedingly seriously. That is how we can provide the utmost care to our patients.

In the proposed legislation, patients will soon find out that government bureaucrats and politicians are driving a wedge between their doctors and themselves. They will see what we will be forced to do in order to practise defensive medicine, based upon a government decree, which will have far-reaching effects not only upon the trusted doctor-patient relationship but also upon how we practise the art of medicine.

This leads me to my third and final point, the law of unintended consequences. One of the most dreadful changes in the proposed Bill 87 is that once physicians have allegations of sexual impropriety or abuse made against them, their licence to practise is automatically revoked and made public—in other words, guilty until proven otherwise, an action which flies in the face of natural justice.

1410

Currently, a panel has the discretion to revoke a doctor's licence on an individual basis, but this change will have far-reaching consequences both on physicians

and patients as well. Physicians will have to change the way they practise. In fact, I am aware of some already starting to do this. Something we currently offer or employ appropriately which we now feel compelled to do is to have chaperones in our examining rooms any time we should do a breast/genital/rectal examination. Patients already feel uncomfortable or embarrassed enough with their doctors, whom they've learned to trust.

Today, with these proposals, we are already feeling a pressure to avoid examining patients for fear that our careers would be ruined under these new laws. We know that innocent physicians' careers and their very lives will be harmed by these proposals. Worse, what about patients—millions of patients' lives? How many skin cancers will we miss because we're afraid to examine a patient's skin thoroughly at a checkup or a complex dermatological consult? How many breast lumps or cancers will be missed because we stopped examining breasts? How many genital, prostate and other pelvic cancers will we miss? How many more tests will be ordered and patients be put through unnecessarily?

What will doctors—our doctors—become? How will patients feel? What will the law's unintended consequences reveal in the years ahead? With these draconian changes, you now produce what we are intending to reduce.

Members of the committee, I ask you—no, I plead with you—to take a hard look into this proposed legislation. I ask you to consider not only what is written on this paper but also what is written on the wall. Is this truly what you feel is right for the patients of Ontario?

The Chair (Mr. Monte McNaughton): Thank you very much, Doctor. We're going to move to Madame Gélinas for questions.

M^me^ France Gélinas: You made it clear that you feel that the bill will change at which point in the process a licence will be revoked. You feel that mistakes could be made and lives could be ruined. Did I hear you well?

Dr. Douglas Mark: Basically, yes, but it basically comes down to "guilty until proven otherwise," and public posting of this as well.

M^me^ France Gélinas: I was worried about that too. When I asked a different college about the timing of when they can revoke a licence—because the colleges have always had the right to revoke a licence—they answered that the process is the same and that the person still has the right to appeal, they will still be notified, they can still retain a lawyer, and they can still appeal this. Did you know that and do you agree with that?

Dr. Douglas Mark: To my understanding, it's not the same, in that it will go public, and then the licence will be revoked in the early stages as opposed to at the end of the investigative process.

M^me^ France Gélinas: When I bring those forward, the person will say that the physicians can appeal and can be represented by a lawyer; and if they didn't get it right, the licence will be reinstated.

Dr. Douglas Mark: It's pretty hard to justify that you're innocent when they've already said you're guilty. Your patients know; the public knows; your family knows. You're not allowed to bill. You can't pay for your own home.

Let me give you an example of the days of the medical review audits committee. In 1996, they changed a couple of words, in that they could collect the monies deemed not billable to be collected by offset. It may be collected by offset. So what did they do? As soon as they identified a doctor who might be billing irregularly, they took the money right away, before they had any chance of justification for the reasons for doing so. They'd even do that again, a second time. After they've gone through the whole process, they'd say, "Oh, here's another one. We're going to get you again." That's just from a few words changed in Bill 26.

M^me^ France Gélinas: Back in 1996?

Dr. Douglas Mark: Yes. Doctors were destroyed by that. I know of at least one death from that.

M^me^ France Gélinas: You talked about driving a wedge between patients and doctors. Can you give me an idea of what you meant when you said that?

Dr. Douglas Mark: That's a good question; thank you. It's really about when we are forced to do something to practise defensive medicine. We're trained—like, if you work in an emergency department—

The Chair (Mr. Monte McNaughton): Doctor, we're going to move to the government now. Mr. Fraser.

Mr. John Fraser: Can you finish answering the question?

Dr. Douglas Mark: Thank you. We are trained that if we don't know the patient and they don't know us, you have to have a chaperone. I would drag nurses kicking and screaming into the examining room with me. They would stand in the room, looking around embarrassed. They're in the room so that the patient has the protection of someone else in the room with them. That is good practice. If you know a patient really well and they trust you to do something and you ask them if they want to have a chaperone in there with them, they'll say no.

We're going to have to be careful because we're worried. Maybe they'll get Alzheimer's one day, or they'll remember something years before and they get things mixed up and, then, before you know it, it's over.

Mr. John Fraser: I want to thank you for your presentation and speaking here today and for your support of zero tolerance.

I want to say, though, that I think your characterization of the situation—we know that the numbers are bigger than that. We're heard from a witness earlier today, a senator who was here who has done some work on this. It is a balance. I understand what you're saying and definitely respect the doctor-patient relationship.

We also heard from Dr. Male, who said that actually RHPA does protect. There's no need for chaperoning simply because—except in the case that you mention—there are already rules inside the regulations that protect physicians. He said that it's just that it's not clear.

I heard your comments in regard to—it's not mandatory suspension; it's a possibility of suspension. We've heard stories where people have multiple offences. At some point, that panel has to make a decision: Are we

actually creating risk for somebody? I understand that that's why that provision is there. I can understand the concerns around that, but I think you have to have it there to get the right kind of balance.

Dr. Douglas Mark: I understand what you're saying. The wording might be the problem here again. To my understanding, the panel that looks at these cases can move things along more quickly and not let things just smoulder and get out of control. What we're afraid of is that they "may" revoke the licence becomes that they "will," like they do with the MRC: "may collect the monies by offset," which meant they did.

Mr. John Fraser: I think there's some sensitivity towards—we've gone through that history of that and—

Dr. Douglas Mark: A bit.

Mr. John Fraser: We may differ on that opinion, but I think there's some understanding in the relationships.

Dr. Douglas Mark: We have to look at the words. When something says "shall" or "will," we know that it's legal terms. If it says "may" or it proposes that they could, then we know they might. Then, if they do it to a doctor who's innocent—think of it: 10 years or 20 years to become a doctor, debt, patient care, and sacrificing their lives and their families for their work.

Dr. Douglas Mark: Doctor, we're going to move now to the official opposition and Mr. Yurek.

Mr. Jeff Yurek: Thanks for being here, Doctor. You didn't touch upon—and maybe you can—the organization's thoughts on access to the doctor's own medical records and the control of the government on all the committees of the health care colleges.

Dr. Douglas Mark: That's been a concern of ours for some time. We've spoken about that in other situations. We are told that the government only wants to see our schedules. Being told one thing and having something written down is different, the way it is worded. What is to stop government bureaucrats from raiding our offices, looking through our schedules, and seeing things in patient records when it's all connected to one computer? We are fearful of that. Patients are not happy about this possibility as well. I've talked to many patients, and they're very, very angry and upset that even looking into our computers to look at our schedules, for instance, is something that we're going to be subjected to. That's our concern.

Mr. Jeff Yurek: Do you find that that's going to affect access to care for patients?

Dr. Douglas Mark: In some ways, perhaps, yes. They know that when I'm typing things on the computer—I let them see what I'm typing, usually. They will say, "Do not put that there," because they know that somebody might have an easier chance of looking at it now, given that it's a computer alone and now with the government having laws in place that they will be looking through our computers.

Mr. Jeff Yurek: The other part of my question is about the committee makeup. This legislation basically just tips the power into the government's hand in selecting the committee. The college has no problem with the discipline, but they want the executive committee power structure to still remain within the health professionals. Your thoughts, if any, on this?

1420

Dr. Douglas Mark: Which committee in particular?

Mr. Jeff Yurek: Discipline, for instance. The government can appoint members, as opposed to the college appointing members.

Dr. Douglas Mark: There have to be checks and balances. I think the public deserves that. It's much like a pendulum on a clock: It can swing one way one day and the other way another day. If, on average, it's balanced and decisions coming out are reasonable, then I would be okay with that. I can't give you a direct answer on that, though.

Mr. Jeff Yurek: Thank you.

The Chair (Mr. Monte McNaughton): Thanks for presenting today.

COMMITTEE BUSINESS

The Chair (Mr. Monte McNaughton): Our committee is just going to deal with a housekeeping item. I believe we have a motion. Ms. Wong.

Ms. Soo Wong: I move that the Chair write a letter to the House leaders expressing the committee's willingness to accept the invitation to attend the 2017 annual meeting of the National Conference of State Legislatures in Boston, Massachusetts, from August 5 to 9, 2017, and request that a motion be presented to the House that the Standing Committee on the Legislative Assembly be authorized to attend the 2017 annual meeting of the National Conference of State Legislatures in Boston, Massachusetts.

The Chair (Mr. Monte McNaughton): All in favour? Carried.

We have a second motion. Ms. Wong.

Ms. Soo Wong: Mr. Chair, I move that the committee approve the budget in the amount of $47,625 for the committee and staff to attend the annual meeting of the National Conference of State Legislatures, and that the final budget be submitted to the Speaker and the Board of Internal Economy for their approval.

The Chair (Mr. Monte McNaughton): Any debate? All in favour? Carried.

PROTECTING PATIENTS ACT, 2017
LOI DE 2017 SUR LA PROTECTION DES PATIENTS

CONCERNED ONTARIO DOCTORS

The Chair (Mr. Monte McNaughton): We now have Concerned Ontario Doctors. Please state your name for Hansard, and then you will have six minutes for your presentation. This round of questioning will begin with the government. You may begin.

Dr. Kulvinder Gill: Good afternoon. My name is Dr. Kulvinder Gill. Thank you for the opportunity to address

the standing committee about Bill 87, on behalf of Concerned Ontario Doctors, a grassroots, not-for-profit organization representing thousands of community and academic family physicians and specialists in every corner of this province.

Recently, over 100 COD members were elected to the council of the Ontario Medical Association. I am the newly elected chair of OMA's district 5, which encompasses the greater Toronto area and the counties of Dufferin, Muskoka and Simcoe. I am also a community physician, a medical educator and the co-founder and president of Concerned Ontario Doctors.

Ontario's doctors have grave concerns over Bill 87, an act that violates the basic human rights of physicians. It has left thousands of front-line physicians fearful. It is unfathomable that this government has introduced this legislation without any consultation with Ontario's physicians. Effective health care reform requires meaningful engagement of all stakeholders, including physicians. It requires genuine collaboration. None of this occurred with Bill 87.

As a pediatrician, I wish to address the new reporting requirement that those who administer immunizations provide information to the local medical health officer. This imposes a greater admin burden, especially given that physicians already spend over one hour on paperwork for every hour spent providing patient care. This is a breach of the representation rights agreement between the Ministry of Health and the OMA. Under article 3, all discussions about physician work and compensation must occur via these negotiations channels.

Some 78% of Ontario's physicians report burnout; 86% of these physicians cite the ongoing abuse and the vilification by this Liberal government as the cause. Burnout very quickly leads down a road of depression, compassion fatigue, substance abuse and suicide. Most suffer in silence while attempting to continue to provide care for their patients until it becomes unbearable. Physician suicide rates are already twice that of the general population. This is a growing public health crisis. Patient outcomes are worse under the shadow of physician burnout, with a rise in medical errors, injury and illness.

As a society, we must not only take care of our patients but also take care of our caregivers.

Sadly, Bill 87 will make the stigma of mental health worse. It will grant the Ministry of Health unprecedented access to the personal and private health records of Ontario's doctors—access without the consent of physicians and without the requirement to demonstrate a concrete need.

Each January, this government advocates and supports Bell Let's Talk Day. Why, then, are barriers being created for physicians to open up about their own mental health challenges with their family doctors? We need to be creating bridges, not building walls around mental illness. This invasion of privacy not only contravenes the privacy principles of the Personal Health Information Protection Act, but it also represents a constitutional violation of the Canadian Charter of Rights and Freedoms under sections 7 and 8.

Bill 87 goes further in violating the basic human right of the presumption of innocence and physicians' right to procedural fairness and natural justice. It makes the College of Physicians and Surgeons into a kangaroo court while denying physicians the right to due process granted to all other Canadians. Once Bill 87 passes, CPSO will publish all patient complaints publicly on their website and have the ability to both temporarily and permanently take away a physician's medical licence before a committee hearing ever occurs and before any evidence is ever presented. The livelihood and the public reputation of the physician, the physician's family, their staff and their staff's family can be forever tarnished without a hearing having ever occurred and without any evidence having ever been presented. This is unjust.

Without consulting with patients, CPSO has now recommended that physicians hire chaperones in their practices to be present for all clinic visits. This is an immense burden on physicians who are already struggling to keep their clinics afloat. The very idea of having a chaperone implies that there is no trust between the patient and the physician. The patient-doctor relationship is the core of medicine. Having a chaperone runs counter to this very principle, and it erodes the very foundation upon which we practise.

Doctors are fearful about putting themselves in harm's way without having due process protections in place against baseless patient complaints. In a survey of Ontario physicians and trainees last week, 81% reported feeling threatened by Bill 87, while nearly 50% already report plans to make changes to how they deliver patient care and 12% plan to leave the province or possibly retire once Bill 87 passes.

Many family physicians have already stopped performing breast, prostate, pap and pelvic examinations, and are now instead ordering ultrasounds or other diagnostics, or simply referring on to academic centres. If Bill 87 passes, more and more physicians will take such measures to protect themselves against the violation of their charter rights. This will lead to more fragmented patient care and longer wait times for specialists and diagnostics while increasing the burden of health care costs.

Ontario's doctors strongly believe that those who commit criminal acts should be prosecuted, and we advocate for harsher and more severe penalties through our judicial system to ensure patients are protected. It is wrong to create a kangaroo court out of CPSO to address the failings of our court system.

Many Ontario physicians are themselves immigrants and/or refugees, and they find it unfathomable that with Bills 84 and 87, there are six violations of the Canadian charter and eight of the UN Universal Declaration of Human Rights. If this government cannot respect and provide—

The Chair (Mr. Monte McNaughton): Dr. Gill, I'm sorry; that's the six-minute time limit. Questions are going to begin with the government: Mr. Fraser.

Mr. John Fraser: Did you want to say something in conclusion?

Dr. Kulvinder Gill: Yes. If this government cannot provide respect and a humane, dignified working relationship with Ontario's doctors, who will be left to care for the most vulnerable? On behalf of Ontario's doctors, I plead with this government to protect the fundamental human rights of Ontario's doctors and ensure that patient care is not further compromised.

Mr. John Fraser: Thank you very much, Dr. Gill. Thank you for appearing again. I think I had a chance to speak to you on Bill 41 as well. Did you present on that as well?

Dr. Kulvinder Gill: Yes.

Mr. John Fraser: Thanks for being here today. I'm glad to hear that you support zero tolerance. It's about balance, so I want to assure you that this committee has heard and I've heard—as I mentioned earlier, I was at an OMA event on Saturday night and spoke to a number of practitioners and physicians, and they expressed their concerns as well. That's being heard. There is work being done currently, right now.

Dr. Male was here earlier talking about the provisions in the RHPA that protect and define that physicians don't necessarily know about, and there may be a certain amount of misinformation and needless anxiety. He spoke a bit about how we could clarify that.

I don't think what we have here is a kangaroo court. I mean, we have a very serious situation that has existed. If we take a look at—you know, we had Senator McPhedran here earlier to talk to us about that. She has done some work with us on that. We read it in the papers. We know it's a very small percentage. The harm that is done is great, so that's why we're looking at this.

1430

I want to ask you one question with regard to the people who are affected by this, the people who are affected by sexual assault. There are some provisions in this bill with regard to early support for those services that they may need. They may need counselling services, support services. We've had some provisions inside the bill with regard to that. If you don't feel prepared to answer—

Dr. Kulvinder Gill: I am familiar with that, but I'm not sure what your exact question is about that provision.

Mr. John Fraser: All right. It's just a provision to ensure that there's early support, and that the support is the responsibility of somebody who is found to be in violation.

Dr. Kulvinder Gill: Right. The concerns that most of the presenters to this committee have already brought forth with that provision is that there are services that are being provided before any sort of hearing has occurred, and before it has been actually ascertained that the physician was guilty and that the allegations that are being brought forth by the patient are in fact true.

Mr. John Fraser: Okay. And how do you—

The Chair (Mr. Monte McNaughton): Mr. Fraser, that's all the time.

Mr. John Fraser: Thank you.

The Chair (Mr. Monte McNaughton): We're going to move to the official opposition, and Mr. Yurek.

Mr. Jeff Yurek: Thanks for being here today. Your point that you raised with regard to the health care professionals having to report vaccinations directly to the health unit—we've had numerous health units in to report that they're concerned. Peel region was saying that something along the lines of probably over 200,000 documents will cross their desks with regard to vaccinations. I'm sure that as a pediatrician, you understand that, and the fact that there won't be up-to-date records available because there will be stacks of paper somewhere and/or duplications or omissions.

Last night, I was speaking with the Information Technology Association of Canada, the people who are creating our digital systems. They're pretty much in agreement that we should hold off on implementing this part of this legislation until the technology exists, so that if and when a doctor completes that vaccination, it's a matter of computer input and done.

Would you agree with holding off going further with this provision until technology is actually readily available?

Dr. Kulvinder Gill: Absolutely. Not only that, but when you look at the research that presently exists, in terms of some of the recommendations that are being brought forward in terms of the immunization education etc., guidelines that currently exist actually are counter to the recommendations. There is presently evidence to the counter. So it's very mind-boggling as to why these recommendations would come forward when they're not evidence-based.

I think Ontario needs to start looking towards how other provinces are presently addressing immunizations. In many western Canadian provinces, they are under the umbrella of the public health. That creates greater access for patients and greater efficiencies within the system. I think Ontario needs to start looking at other provinces that are actually doing it better.

Mr. Jeff Yurek: I know what you're saying about the western provinces. Do you think it would be plausible to have a physician sign off that they have educated their patient with regard to vaccinations, seeing how, as a pediatrician, you'd see the baby multiple times, as opposed to forcing them to go to a class?

Dr. Kulvinder Gill: I can tell you, as a pediatrician, and speaking to my family medicine colleagues, that education is an ongoing dialogue. Oftentimes, when parents come in, if they're not pro-vaccination, that trust is built, or that rapport is actually built, over multiple clinic visits. Then, oftentimes, the families do come to understand the critical need to have their children immunized, but that requires the building of trust in the doctor-patient relationship, and that's an ongoing dialogue.

The Chair (Mr. Monte McNaughton): Doctor, we're going to move to the third party now, and Ms. Gélinas.

M^me^ France Gélinas: Pleased to see you, Dr. Gill.

Dr. Kulvinder Gill: It's nice to see you too.

M^me^ France Gélinas: I want to continue in that line of thought, but kind of different. What you said is not really

that you were opposed to doing the reporting. You were opposed to this being imposed upon you without respecting the negotiating channel that the government had had already signed off. The way I understand it is that the OMA represents physicians like yourself, and if the government wants physicians to do something, to start providing a new service, those are supposed to be negotiated at that table.

I wanted to make the distinction: Are you opposed to reporting to the health unit, because the health unit doesn't have the capacity to take this information in? Or are you opposed because it's disregarding the negotiation that should have taken place?

Dr. Kulvinder Gill: I believe that's sort of a twofold answer. The first goes towards the comments that MPP Yurek had made, in that there is currently no infrastructure that exists to allow for that reporting in a very efficient manner.

The second goes towards this government expecting physicians to do more and more with less and less. We are already struggling to keep our clinics afloat. Many physicians have already had to lay off staff. Adding this further admin burden will take away from the front-line patient care that doctors are presently providing.

M^me^ France Gélinas: The other point you made was, why is it that the government wants access to your personal health information? I fully support what you're saying there, that physicians have to have the same rights as everybody else. If they are sick, if they have an illness, they have to be able to go to the health care provider with the assurance that what they share there will never come out. I don't support this, and I will do my best to take that out of the bill. I don't support the government having access to physicians' or any other health professionals' health information—or anybody else's, for that matter. Was it ever explained to the OMA, or to yourself, why this was put in?

Dr. Kulvinder Gill: No. It has been asked many times. There has never been any sort of direct answer given.

M^me^ France Gélinas: So it's not through lack of asking for a response. There is no response coming?

Dr. Kulvinder Gill: Correct.

M^me^ France Gélinas: I'm in the same boat. Thank you.

The Chair (Mr. Monte McNaughton): Thank you very much, Dr. Gill, for your presentation.

Dr. Kulvinder Gill: Thank you.

ONTARIO PUBLIC SERVICE EMPLOYEES UNION, HOSPITAL PROFESSIONALS DIVISION

The Chair (Mr. Monte McNaughton): I would now like to call upon the Ontario Public Service Employees Union, hospital professionals division, please.

Good afternoon. Welcome. If you would begin with your names please, for Hansard. You have six minutes for your presentation. Questions will begin with the official opposition.

Ms. Sara Labelle: Thank you. My name is Sara Labelle, and I am the chair of the hospital professionals division, representing 25,000 hospital professionals. With me today is Kim Johnston. She is our communications and campaigns officer who helps with health care. Thank you for allowing me the opportunity to present today on Bill 87, the Protecting Patients Act. I am also a medical laboratory technologist by profession, and I work at Lakeridge Health in Oshawa.

While there are several aspects of the bill that are worth exploring, I would like to take this opportunity to focus on two specific amendments to the Laboratory and Specimen Collection Centre Licensing Act, which impacts the Health Insurance Act and the Public Hospitals Act by expanding the role of community hospital labs and changing the community lab funding model—rather, the government pays private and, more often than not, for-profit laboratories in this province.

Expanding the definition of community lab services to include hospitals would allow hospitals to provide the services to individuals who are not in-patients or out-patients of the hospital. This was previously considered community laboratory services. The minister can also now designate hospitals to provide community lab services.

I agree that community hospitals should have the ability to provide those services. In fact, it is our argument here today that community hospitals should provide all laboratory services.

But we are concerned. First, we are concerned about the increased pressure that this plan will put on already overstretched community hospitals. Secondly, we're concerned that this amendment is focusing in on northern and rural hospitals for the wrong reasons, and we'll come back to this in a moment. Finally, we're concerned because the government should be working to bring all laboratory services under the umbrella of public medicare, like what is happening right now in Alberta.

Historically, lab services were housed in community hospitals, but for more on the history of public versus private labs, please see OPSEU's submission, because I only have six minutes.

Hospitals, after all, are the public, non-profit health care hubs within our communities. All of us at some time or another will require hospital services and most likely will need hospital laboratory services as well.

Ontario's hospitals are at a breaking point. How can our hospital labs take on more responsibility when Ontario's community hospitals have been pushed to the breaking point? We have endured nine years of deep and devastating cuts to hospital beds, services and staff. No peer jurisdiction has undertaken such radical cuts to community hospitals, and by virtually every measure, Ontario now ranks at the bottom of comparable jurisdictions on hospital care levels. Our hospital labs have been decimated.

1440

The recent Ontario budget doesn't go anywhere near far enough in undoing the damage that has been done, and our community hospital labs cannot—I repeat: absolutely cannot—take on more work without the proper funding to match it.

The second matter I want to discuss today is the fee-for-service funding model. Fee-for-service is a highly flawed method of payment. It benefits for-profit corporations that set up in urban areas where high volumes are easily achieved, and is detrimental to small rural and northern communities where services are regionalized to make the volumes worthwhile financially. Sault Ste. Marie has been decimated through this model. An elite few have managed to make a lot of money under this model on the backs of regular Ontarians. In fact, in Ontario, two corporate entities have been permitted to hold 95% of the community laboratory market.

While we would be thrilled for the government to walk away from a fee-for-service model to a fully public funding model, that doesn't appear to be the government's goal here. Based on recommendations this government received from a so-called Laboratory Services Expert Panel report in 2015, they may be moving away from the fee-for-service model, but likely to open the door to a competitive bidding model. While we are not completely surprised by this move, we are deeply disappointed.

This government needs to understand that there is no place for privatization and profit-taking in our public medicare system. But coming back to the point I began making earlier about northern and rural communities, with lower populations and vast tracts of land, competitive bidding is not an ideal model in rural and remote regions. We're concerned that the amendment to allow hospitals to take on community lab services is not being done for the right reasons. Instead, we are concerned that it is a safety valve so that in regions where the competitive bidding process fails, those community laboratory services can be delegated to the local community hospitals, who are the tried and true providers of public health care.

But competitive bidding is not the solution. Competition does not drive efficiency and provide quality care at a lower price. Just look at the research done by Ross Sutherland, expert and author of False Positive: Private Profit in Canada's Medical Laboratories. By the most conservative analysis, for-profit labs cost the Ontario health care system at least 25% more, and this depends on whether you look at the HICL model or the government's own review.

If you want to see value for money, look at the 2007 results of an Ontario pilot project in which RPO Management Consultants determined that costs at public hospitals averaged $22 per test, compared to $33 for the same tests in the large for-profit labs.

By Sutherland's analysis, the Ontario health care system could save between $175 million and $200 million per year by integrating community lab services with hospital labs.

If the government's priority is patients, it's time to stop the flow of public dollars into private hands, and this includes moving to a competitive bidding model in the lab sector. All community lab services should be fully integrated into our community hospital labs, which are the public, non-profit health care hubs in our communities.

The Chair (Mr. Monte McNaughton): Excellent. Thank you very much. We'll begin with Mr. Yurek.

Mr. Jeff Yurek: Thanks very much for coming in and delivering your report.

You want to move away from LifeLabs, Dynacare and Alpha labs from being any part of the system?

Ms. Sara Labelle: Yes.

Mr. Jeff Yurek: So you'd replace them with government-run labs, or would you—

Ms. Sara Labelle: With our already existing infrastructure, with our community hospital labs. Every single community hospital has a lab. You already have the infrastructure; you have the staff; you have the equipment available. We're essentially double-paying by having a private corporation deliver the same services, and all they're doing is trying to skim the cream—which is the high-volume, high-billing tests—off the community hospitals and leaving the hospitals then to do the labour-intensive, difficult, high-cost tests. It actually makes the system more inefficient.

Mr. Jeff Yurek: Just a question: With the closing of numerous rural hospitals, wouldn't that be limiting patients from accessing labs, if they have to travel a further distance?

Ms. Sara Labelle: Actually, we lost access points when they closed hospitals to providing community services a few years ago, when they forced the closure of—like, the ability for the hospital labs to do that work. We lost 225 access points in the province of Ontario. They have never come back. Those private clinics are not opening up in small communities. They are not opening their doors in an area where they're not getting the volume. All the volume is in larger urban centres.

Mr. Jeff Yurek: So that's already occurred under this government.

Ms. Sara Labelle: Yes.

Mr. Jeff Yurek: Okay. I just wanted a clarification. Thanks.

The Chair (Mr. Monte McNaughton): Great. Thanks. Madame Gélinas?

M^me^ France Gélinas: Thank you so much, Sara, for coming, and thank you for what you've presented.

I wanted to bring you in a little bit of a different direction. Everybody looks at the bill and says it will allow hospitals to take on community labs. But it would also allow the private labs to do more and more of the hospital lab work, would it not? Am I the only one who saw that this door opened at the same time?

Ms. Sara Labelle: No, that's exactly what it was. There was a hard lobby by the private sector and by the private labs to take on more volume from the actual hospitals, because they want to do more of the work. Again, it's the high-volume, high-billable tests that they

want access to. The hospitals right now are currently doing all the in-patients and anybody who's attached to an out-patient clinic, so it would significantly increase their volume.

The private lab industry in Canada is over $1 billion a year, and if they were now able to access the in-patient hospital testing and the people attached to clinics, it would probably double, at least.

M^me^ France Gélinas: So I'm not the only one who saw—

Ms. Sara Labelle: No, you're not the only one who saw that.

M^me^ France Gélinas: —that door opening in both ways. It's very worrisome for me too.

I come from northern Ontario. We have lost all of our points of access except for a hospital, and 111 Larch Street in downtown Sudbury still has a LifeLabs. Is this happening elsewhere? In big centres is it the same thing, where the big private labs have one big centre and everybody else around within 100 kilometres has to be brought in, or is this solely a northern and rural affair?

Ms. Sara Labelle: This is happening everywhere. There are private labs, and there are also clinics that are collecting the samples and then sending them to the private labs. The problem is that with that model—this is happening in the urban centres, like Oshawa. We have clinics that collect the samples, but when they have a difficult collection, when they have results that they want to have access to immediately because it's an urgent situation, they are sending their patients from that clinic up to the hospital. We can't bill for those tests. It's coming out of our global budgets. They're essentially taking access away from the hospitals, but when they need us they want us to do the work. That's happening in every single community, that they're losing their access points for actually getting their testing done.

And people have to travel. Uxbridge hospital does a lot of the out-patient services still. People who require their PTT—which is a test for Coumadin—have to go into the hospital and get that work done.

M^me^ France Gélinas: Have the private labs started to charge for people who need their tests done at home? If they send a phlebotomist to your home to draw blood, do people have to pay down south, or is it only up north where they charge us?

Ms. Sara Labelle: No, there are 138 clinics operating across Canada. I don't know the exact number for the province of Ontario—

The Chair (Mr. Monte McNaughton): Sorry. We're out of time. We're going to move to the government, please, and Ms. Malhi.

Ms. Sara Labelle: —and 115 are billing patients. Sorry.

The Chair (Mr. Monte McNaughton): Go ahead. Questions?

Ms. Harinder Malhi: Thank you so much. As you mentioned earlier, we have proposed almost a $500-million increase to the hospital sector in the 2017 budget. With this, we could compensate hospitals for the services that they're providing in the same way that labs are now being compensated. Could you speak to how that could benefit hospitals?

Ms. Sara Labelle: It would benefit them that they could bill for them and get paid for them, but it's a bad model, because the competitive bidding model does not usually benefit the public not-for-profit sector. The competitive bidding ends up benefiting the private sector, and it costs more. We've already seen that in home care: In every jurisdiction where a competitive bidding model has been introduced, it has not worked.

Ms. Harinder Malhi: But if the hospitals are able to bill the same way as the labs, at least they're able to now get more funding for the services that they're providing.

Ms. Sara Labelle: It would be better if this government would just properly fund hospitals for the services that they need to provide in their communities, rather than creating another competitive bidding model. It didn't work in home care.

Ms. Harinder Malhi: As we've said, we are looking at making investments in health care as we did in the 2017 budget, but I thank you for your opinion.

Ms. Sara Labelle: Yes, I know: your $518 million that doesn't come even close to meeting the needs of hospitals.

The Chair (Mr. Monte McNaughton): Any further questions?

Thank you very much for presenting today.

Ms. Sara Labelle: Thank you.

The Chair (Mr. Monte McNaughton): I'd like to thank committee members. We're done the public presentations now. I just want to remind everyone that amendments are due on Monday by noon—

Interjection.

The Chair (Mr. Monte McNaughton): —and summary by 5 tomorrow.

Next Wednesday, we'll begin clause-by-clause, and we'll be back to our regular meeting time, which is 1 o'clock until 3 o'clock. We'll see everyone next Wednesday.

The committee adjourned at 1450.

STANDING COMMITTEE ON THE LEGISLATIVE ASSEMBLY

Chair / Président
Mr. Monte McNaughton (Lambton–Kent–Middlesex PC)

Vice-Chair / Vice-Présidenté
Ms. Laurie Scott (Haliburton–Kawartha Lakes–Brock PC)

Mr. Robert Bailey (Sarnia–Lambton PC)
Mr. James J. Bradley (St. Catharines L)
Mr. Joe Dickson (Ajax–Pickering L)
Ms. Sophie Kiwala (Kingston and the Islands / Kingston et les Îles L)
Ms. Harinder Malhi (Brampton–Springdale L)
Mr. Michael Mantha (Algoma–Manitoulin ND)
Mr. Monte McNaughton (Lambton–Kent–Middlesex PC)
Ms. Laurie Scott (Haliburton–Kawartha Lakes–Brock PC)
Ms. Soo Wong (Scarborough–Agincourt L)

Substitutions / Membres remplaçants
Mr. John Fraser (Ottawa South L)
M^{me} France Gélinas (Nickel Belt ND)
Mr. Jeff Yurek (Elgin–Middlesex–London PC)

Clerk / Greffier
Mr. William Short

Staff / Personnel
Ms. Carrie Hull, research officer,
Research Services